

California Major Risk Medical Insurance Program



Major Risk Enrollment Unit
(800) 289-6574

1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695

Gray Davis, Governor

Board Members

Tal Finney, Chairman
Soap Dowell
Sandra Hernández, M.D.

Executive Director

Sandra Shewry

Table of Contents

Introduction	2
Eligibility	2
How the Program Works	3
Description of Plans and Benefit Highlights	
Blue Cross of California	8
Blue Shield of California (HMO)	10
Blue Shield of California (PPO)	12
Contra Costa Health Plan	14
Kaiser Permanente Northern California	16
Kaiser Permanente Southern California	18
Maxicare	20
Rates	22
Enrollment Checklist	28
Application	29

Americans With Disabilities Act

Section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall, on the basis of disability, be excluded from participating in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

California Government Code Section 11135 prohibits discrimination under a program or activity funded directly by the state or that receives financial assistance from the state on the basis of ethnic groups identification, religion, age, sex, color or disability. California Government Code Section 11136 requires state agencies, as described above, to notify a contractor of whom they have reasonable cause to believe has violated the provisions of Section 11135 or any regulation adopted to implement such section. After considering all evidence, the Executive Director of the Managed Risk Medical Insurance Board may request a hearing to take place in order to determine whether a violation has occurred.

The Americans with Disabilities Act of 1990 prohibits the Managed Risk Medical Insurance Board and its contractors from discriminating on the basis of disability, protects its applicants and enrollees with disabilities in program services, and requires the Board to make reasonable accommodations to applicants and enrollees that do not pose undue hardship on the Board.

The Managed Risk Medical Insurance Board has designated an ADA Coordinator to carry out its responsibilities under the Act. If you as a client, have any questions or concerns about ADA compliance by the Board or its contractors, you may contact the Coordinator at the following address:

ADA Coordinator
Managed Risk Medical Insurance Board
1000 G Street, Suite #450,
Sacramento, CA 95814
(916) 324-4695 (Voice)

Introduction

The California Major Risk Medical Insurance Program (MRMIP) is an innovative program developed to provide health insurance for Californians who are unable to obtain coverage on the open market. The MRMIP is administered by a five-member Board who has established a comprehensive benefit package. Services in the MRMIP will be delivered through contracts with health insurance providers. Californians qualifying for the MRMIP will participate in the payment for the cost of their coverage by paying premiums on their own behalf. The MRMIP will supplement those premiums to cover the cost of care. The MRMIP is funded by \$40 million from tobacco tax funds.

Eligibility

In order to be eligible for the Major Risk Medical Insurance Program:

1. You must be a resident of the state of California. A resident is a person who is present in California with intent to remain in California except when absent for transitory or temporary purposes. However, a person who is absent from the state for a period greater than 210 consecutive days shall not be considered a resident.
2. You cannot be eligible for both **Part A** and **Part B** of Medicare, unless eligible solely because of end-stage renal disease. (Being eligible for one part or the other is acceptable.)
3. You cannot be eligible to purchase any health insurance for continuation of benefits under COBRA or CalCOBRA. (COBRA and CalCOBRA refer to the state and federal laws giving people under

certain circumstances the right to continue coverage in an employee health plan for a limited time.) If you have COBRA or CalCOBRA you may apply for deferred enrollment.

4. You must be unable to secure adequate coverage. This can be demonstrated in any of four ways:
 - If you have been denied individual coverage within the previous 12 months. A letter/copy of a letter from a health insurance carrier, health plan or health maintenance organization denying individual coverage within the last 12 months must be submitted with your completed application.
 - If you have been involuntarily terminated for health insurance coverage within the previous 12 months for reasons other than nonpayment of premium or fraud. A letter/copy of a letter indicating involuntary termination from a health insurance carrier, health plan, health maintenance organization or employer for reasons other than nonpayment of premium or fraud must be submitted with your completed application.
 - If you have been offered, in the previous 12 months, an individual, not a group, health insurance premium in excess of the Major Risk Medical Insurance Program subscriber rate for your first-choice participating health plan. A letter/copy of a letter must be submitted with the completed application indicating that, within the last 12 months, you have been offered by a health insurance carrier, health plan or health maintenance organization, a premium for the subscriber and/or their dependents (when applicable) in excess of the MRMIP rate for the subscriber and/or their dependents.

- If you are a member of a group of one (not including dependents) who has been denied health insurance coverage in the previous 12 months. A letter/copy of a letter indicating that a member of a group of one has been denied by a health insurance carrier or health plan or health maintenance organization for health insurance coverage within the last 12 months must be submitted with your completed application.

Note: Letters from agents/brokers indicating that an individual is unable to secure adequate private coverage will not be accepted as documentation for eligibility.

Applicants Who Know They Are Currently Not Eligible But Expect To Be in the Future

If you are not currently eligible for the MRMIP, but anticipate becoming eligible, you may also apply. Examples of this are: if you are currently enrolled in COBRA or CalCOBRA coverage or if your employer has informed you that you will be involuntarily terminated from insurance coverage sometime in the future.

To apply for a deferred enrollment, indicate when you will become eligible and include acceptable documentation. Acceptable documentation is a letter from a health insurance carrier, health plan, health maintenance organization, or employer indicating when your coverage will end. The documentation must specify the exact date of termination of current coverage. Enrollment in temporary policies does not qualify for deferred status.

If the MRMIP is not at maximum enrollment and all other eligibility criteria are met, you will be enrolled in

the MRMIP on the date that eligibility will occur. If the MRMIP is at maximum enrollment at the time you become eligible, your place on any waiting list is determined by the date on which your complete application was received, not the date that you became eligible for the MRMIP.

Applicants for deferred enrollment must submit their initial subscriber contribution with their application.

Payment will be refunded to you immediately if your deferred effective date is more than sixty (60) days from the date we receive your application.

Agents/Brokers, Employers and Applicants

Insurance Code Section 12725.5 states that it shall constitute unfair competition for an insurer, an insurance agent or broker, or administrator to refer an individual employee, or their dependent(s) to apply to the MRMIP for the purpose of separating that employee, or their dependent(s) from group health coverage provided in connection with the employee's employment.

Insurance Code Section 12725.5 further states that it shall constitute an unfair labor practice contrary to public policy for any employer to refer an individual employee or their dependent(s) to the MRMIP or to arrange for an individual employee or their dependent(s) to apply to the MRMIP for the purpose of separating that employee or their dependent(s) from group health coverage provided in connection with the employee's employment.

Medi-Cal Beneficiaries

While Medi-Cal beneficiaries are not prohibited from enrolling in the Major Risk Medical Insurance Program, a Medi-Cal beneficiary should carefully consider the cost before signing up for our additional coverage. MRMIP subscribers are responsible for their monthly subscriber contributions, a deductible and/or a co-payment for services which could be up to \$4,000 per year. Medi-labels cannot be used for MRMIP co-payments.

How the Program Works

Choosing a Health Plan

The health plans participating in the Major Risk Medical Insurance Program provide comprehensive medical benefits for inpatient and outpatient hospital and physician services. These benefits are outlined in the health plan description pages in this brochure and are also available by calling any MRMIP health plan at their toll-free number and asking for an Evidence of Coverage or Certificate of Insurance. Subscriber contributions and the availability of each health plan appear in this brochure. Please review all pages carefully to select a plan that is right for you.

Benefits and Co-payments

Subscribers may choose from any plan available to them as listed in the enclosed subscriber contribution by county charts. Health Maintenance Organizations (HMOs) in MRMIP require a fixed dollar co-payment for some services and up to a 20% co-payment for other services. The Preferred Provider Organizations (PPOs) in MRMIP may also require a

fixed dollar co-payment for certain services and up to a 25% co-payment for other services. The out-of-pocket maximum per **calendar** year for all MRMIP plans is \$2,500 for individuals and \$4,000 for an entire household covered by the MRMIP. This maximum does not apply to services received by providers that do not participate in the subscriber's chosen health plan's provider network, or to services not covered by the MRMIP. There are MRMIP benefit limits of \$75,000 per calendar year and \$750,000 in a lifetime.

Subscriber Contributions

Subscriber contribution amounts are updated on January first of each year. In addition, your subscriber contribution may change during the year if your birthday moves you into a new age category. For married subscribers enrolled under two-party or family coverage, the age rating category will be based on the age of the subscriber. Adjustments to subscriber contributions due to age changes will occur on the first of the month following the birthdate.

Subscriber contributions may also change when a member moves from one area of the state to another. Adjustments to subscriber contributions will occur on the first of the month following notification of the move.

Each month you will receive a subscriber contribution notice from MRMIP. Subscriber contributions are payable in advance and are due the first day of every month. A subscriber contribution notice will be generated monthly, and will be sent out 30 days prior to the due date.

Subscribers will be responsible for their monthly subscriber contributions whether or not they receive a bill in that month, or if the premium is paid by a third party.

A delinquency billing or final notice will be sent out on the 15th day following the paid to date.

There is a grace period of 31 days from the paid to date, and the member's coverage will remain in effect during this time.

Cancellation for nonpayment of subscriber contribution will take place on the 32nd day following the paid to date. The cancellation will be retroactive to the paid to date, and a cancellation letter will be generated to the subscriber. Subscribers who are disenrolled for nonpayment of their subscriber contributions may be reinstated only upon request **once** in a rolling 12-month period. Any further reinstatements will require an appeal to the Managed Risk Medical Insurance Board for consideration.

A subscriber may pay either by check or money order. In addition, a subscriber may elect to have their monthly subscriber contribution automatically deducted from their checking account when accepted into the MRMIP.

Subscriber contribution checks and electronic withdrawals that are returned by the subscriber's bank may result in disenrollment back to the last month(s) paid and will result in being charged a returned item processing fee. In addition, electronic withdrawals that are returned unpaid from the subscriber's bank will result in removal from electronic withdrawal and require immediate payment by check or money

order. Upon request to reinstate, the subscriber must include a replacement check of subscriber contributions to bring the account to current status with an additional \$25.00 returned item processing fee. Subscribers disenrolled due to the submission of two checks returned for insufficient funds during a rolling 12-month period will not be reinstated.

There is no application fee for applying to the MRMIP. You are required to submit your first month's subscriber contribution for MRMIP health care coverage, which is completely applied toward your first month of coverage if you are enrolled. Qualified insurance agents and brokers may be paid a \$50 fee by the state for explaining the MRMIP and assisting you in completing the application. The state does not require an individual applying to the MRMIP to pay any fee, charge or commission to a broker or agent.

Pre-Existing Condition Exclusion Period for Blue Cross and Blue Shield PPO Subscribers

For individuals who are enrolled in a participating health plan offering a Preferred Provider Organization (PPO), there is a pre-existing condition exclusion period of 90 days. During this period, no benefits or services related to a pre-existing condition shall be covered. Subscribers shall be required to pay subscriber contributions during this period.

"Pre-existing condition" means any condition which during the six months immediately preceding enrollment in the MRMIP for which medical advice, diagnosis, care, or treatment, including

use of prescription drugs, was recommended or received from a licensed health practitioner during that period.

Post-Enrollment Waiting Period for Blue Shield HMO, Contra Costa Health Plan, Kaiser Permanente and Maxicare

For individuals who are enrolled in a Health Maintenance Organization (HMO) participating health plan, there is a post-enrollment waiting period of 90 days. Subscribers and enrolled dependent(s), if any, will not be eligible for health care services during this period. Subscribers and enrolled dependent(s), if any, will be notified when this period begins and ends. The initial one-month subscriber contribution that is submitted with the application will be applied to the first month of service eligibility. Subscribers shall not be required to pay any other amount during this waiting period.

How You May Waive All or Part of the Exclusion/Waiting Period

The exclusion/waiting period requirement may be waived in part or all if:

1. The subscriber and enrolled dependent(s), if any, have been on the MRMIP waiting list for six months or longer. In this circumstance the exclusion/waiting period will be completely waived.
2. The subscriber and enrolled dependent(s), if any, have been insured by another health insurance policy (including any MRMIP-related temporary or interim insurance policy, MediCare and Medi-Cal) for at least 90 days at the time the application is made to the MRMIP or were covered by another

health insurance policy for at least 90 days and application for eligibility in the MRMIP was made within 62 days following the termination of that coverage. In these circumstances you may completely waive the 90 day period. If the coverage was less than 90 days but was at least 30 days, the subscriber and enrolled dependent(s), if any, will be given credit for either 30 or 60 days toward their MRMIP exclusion/waiting period.

3. The subscriber and enrolled dependent(s), if any, were previously receiving coverage under a similar program in another state within the last year. In this circumstance the exclusion/waiting period will be completely waived.

Please submit appropriate documentation and check the appropriate boxes on the application (Questions 6 and/or 7 in the Program Eligibility Section) if you have met the criteria in #2 or #3 to waive this exclusion/waiting period.

All documentation must be received prior to or with your first month's subscriber contribution.

Dependent Coverage Information

1. Dependents may be covered under the MRMIP and are defined as a subscriber's spouse and any unmarried child who is an adopted child, a stepchild or a recognized natural child. A child ceases to be a dependent upon marriage or age 23, whichever comes first.

A dependent also includes any unmarried child who is economically dependent upon the applicant. An unmarried child over 23 years old may be covered if that unmarried child is incapable of self-support because of physical or mental disability which occurred before the

age of 23. An applicant must provide documentation in the form of doctors' records which show that the dependent child cannot work for a living because of a physical or mental disability which existed before the child became 23.

A dependent of a subscriber can seek independent enrollment in the MRMIP if their separate program eligibility can be documented.

2. It is the responsibility of subscribers to notify the MRMIP of changes in the number of dependents. Coverage for newborn or adopted children shall begin upon birth or adoption of the child. Coverage for stepchildren shall begin upon marriage by a subscriber to the stepchildren's parent. In all cases, the MRMIP must be notified within 30 days. All other dependents are covered within 90 days of the MRMIP being notified. To add a dependent to your policy, you may request an "Add Dependent" application by calling (800) 289-6574 and talking to a MRMIP Enrollment Unit representative.
3. Enrolled dependents of a deceased subscriber or dependents of a subscriber who becomes eligible for Medicare (Parts A and B) are eligible to continue coverage in the MRMIP for as long as the enrolled dependents continue to pay subscriber contributions and meet the definition of dependent as explained in #1 above.

Waiting List

If the MRMIP reaches maximum enrollment, applicants and dependents will be placed on a waiting list. Applicants and dependents will be enrolled when spaces become available in order of the date of receipt of a

complete application. Any time spent solely on the waiting list does not count toward your ninety (90) day pre-existing condition exclusion period or post-enrollment waiting period (once enrolled) unless you have been on the waiting list for at least six months. If you have been on the waiting list six months or longer, your 90-day exclusion period will be waived.

Transfer of Enrollment

Subscribers and enrolled dependents may transfer from one participating health plan to another if either of the following occurs:

1. The subscriber requests a transfer because the subscriber has moved and no longer resides in an area served by the health plan in which they are enrolled and there is at least one participating health plan serving the subscriber's new area.
2. The subscriber or participating health plan requests a transfer in writing because of the failure to establish a satisfactory subscriber/plan relationship and the executive director determines that the transfer is in the best interests of the MRMIP and there is at least one participating health plan serving the subscriber's area.

Any transfer request must be in writing to:

*Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814.*

Subscribers who transfer enrollment are not subject to pre-existing condition/waiting period exclusions.

Disenrollment

A subscriber and enrolled dependents will be disenrolled from the MRMIP without notice when any of the following occur:

1. The subscriber so requests in writing. Disenrollment will be effective at the end of the month in which the request was received or as of the last paid date.
2. The subscriber fails to make subscriber contributions in accordance with the MRMIP's existing subscriber contribution payment and grace period practices. The effective date of disenrollment for nonpayment of a subscriber contribution will be retroactive to the last day for which a subscriber contribution was paid.
3. The subscriber fails to meet the residency requirement or becomes eligible for Part A and B of Medicare unless eligible solely because of end-stage renal disease or the subscriber or enrolled dependent has committed an act of fraud to circumvent the statutes or regulations of the MRMIP. Disenrollment will be effective at the end of the month in which the notification was received or as of the last paid date. In the event of fraud, the disenrollment could be effective to the original effective date.

Subscribers who have been disenrolled may not re-enroll in the MRMIP for a period of one year.

Dispute Resolution/Appeals

If a subscriber is dissatisfied with any action, or inaction, of the plan/provider organization in which they are enrolled, the subscriber should first attempt to resolve the dispute with the participating plan/organization according to its established policies and procedures.

This is a state program and the subscriber's rights and obligations will be determined under Part 6.5 Division 2 of the California Insurance Code and the regulation of Title 10, Chapter 5.5.

Subscribers may file an appeal with the Board over (1) any actions or failure to act which has occurred in connection with participating health plan/organization coverage, (2) determination of an applicant's or dependent's eligibility, (3) determination to disenroll a subscriber or dependent and (4) determination to deny a subscriber request or to grant a participating health plan request to transfer the subscriber to a different participating health plan. More information on the appeals process may be obtained by writing to:

*Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814.*

Binding Arbitration

Binding arbitration is an agreement between some insurance plans and subscribers to have health care disputes reviewed by a neutral person. After reviewing all the facts and hearing both sides, the neutral person makes a decision. Both parties agree to accept the decision.

Does the plan require its members to use Binding Arbitration to resolve disputes?

Blue Cross: No

Blue Shield: No

Contra Costa Health Plan: No

Kaiser Permanente: Yes (includes medical and hospital malpractice)

Maxicare: Yes (excludes malpractice)

Coverage Brochures

Health coverage brochures are available from each health plan upon request. Please see each health plan description for a phone number to call to request one.

Coordination of Benefits

MRMIP will coordinate its coverage of benefits with any other health insurance you may have and by state law will only pay after your other insurance has paid (not including Medi-Cal and other state programs). Under the rules of the MRMIP, the benefits of this Program will not duplicate coverage you may have (whether you use it or not) under any other program or plan.

